Personnel
INTRODUCTION

A characteristic of early intervention services for infants and toddlers with disabilities and their families is the involvement of professionals from multiple disciplines working collaboratively as a team to meet the needs of the child and family, guided by the resources, concerns, and priorities of the family as related to the development of the child.

The qualifications for the various personnel who may provide services in First Steps, Kentucky's Early Intervention System (KEIS), under the Individuals with Disabilities Act (IDEA), Part C, are based on the highest requirement in Kentucky applicable to the person's specific profession or discipline, as required by 34 CRF 303.361. This means that personnel in a specific profession or discipline must hold the highest entry-level academic degree needed for approved or recognized certification, licensing, registration, or other comparable requirements that the Kentucky legislature has either enacted or has authorized a State agency to promulgate through rules to establish entry-level standards for employment in that profession or discipline. All personnel must maintain standards consistent with any certification, licensure, registration, or other comparable requirement in Kentucky applying to the profession or discipline in which the person is providing early intervention services.

In addition to listing the qualifications required of the various personnel that may provide services in First Steps and providing guidelines for meeting those qualifications, this section delineates the roles of each discipline and service provider. Roles for the various disciplines were identified through broad-based research and through feedback from professional associations and licensing boards in Kentucky, university faculty, and practitioners, as well as from Kentucky's Early Intervention System Interagency Coordinating Council (KEIS-ICC).

The delineation of the roles for professionals and paraprofessionals providing early intervention services in Kentucky is based on two premises. The first premise is that a common body of knowledge and skills is applicable to infant/toddler services and is required by professionals or paraprofessionals from any discipline. Knowledge of typical and atypical development in infancy and skills in functioning as a member of a team are examples of this generic core. Thus, personnel in First Steps are generalists in that they share knowledge of key concepts and skills in key practices. In addition, some roles in early intervention require certain knowledge and skills, but do not require that a certain discipline perform them. These also are viewed as general roles.

The second premise is that no one discipline is able to provide all the services or possess all the expertise required to meet the needs of infants and toddlers with disabilities and their families. Early intervention personnel come from a variety of professions and have received highly specialized training in their particular field. Therefore, in addition to possessing a common base of knowledge and skills in the field of early intervention, personnel also are specialists within that field who possess knowledge and skills specific to the practice of their own discipline.

Thus, personnel need both a common framework of knowledge particular to the uniqueness of early intervention practices as well as training and expertise specific to a discipline. Roles of all providers, both professionals and paraprofessionals, are to be performed within the expertise, discipline, and scope of licensure or certification (if applicable) of the team member.

In addition, this section delineates the qualifications and roles for providers in the First Steps system for which no specific degree, certification, or licensure exists for the particular type of service being provided (e.g., service coordination). These services may be performed by personnel from a variety of disciplines if the provider of the service possesses the specific qualifications delineated for the type of service being performed and if the provider is able to fulfill the roles specific to that type of service as well as the general roles which all personnel must fulfill.

Finally, all personnel providing services in First Steps must be approved by the Cabinet for Health Services.

REFERENCES

Bailey, D.B., Simeonsson, R.J., Yoder, D.E. & Huntington, G.S. (1990). Preparing professionals to serve infants and toddlers with handicaps and their families: An integrative analysis across eight disciplines. Exceptional Children, 57(1), 26-34.

California Early Intervention Personnel Study Project (January 1990). California Early Intervention Personnel Preparation Plan. San Francisco, CA: San Francisco State University, Department of Special Education.

McCullom, J.A. & Thorpe, E.K. (1988). Training of infant specialists: A look to the future. Infants and Young Children, 1(2), 55-65.

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POLICY I: *First Steps providers shall meet the qualifications specified in 908 KAR 2.150 and shall maintain documentation on file at their work site of those qualifications.*

PROCEDURES:

1. Licensed and/or certified professionals as identified in 908 KAR 2.150 shall maintain a copy, or proof, of their degree and of the required license or certification. See Attachment: Table of Qualifications for Professional Personnel.

   A. Developmental Interventionists who do not currently hold valid Kentucky Interdisciplinary Early Childhood Education (IECE) certification as required in 908 KAR 2:150 shall have a bachelor's degree and (1) have a valid out-of-state certificate for teaching infants and toddlers with disabilities or (2) be working towards an IECE certificate by being enrolled in an approved preparation program or by having a professional development plan.

      (1) A person who holds a valid out of state teacher certificate that includes children birth through two years with disabilities shall submit a copy of the certificate, including documentation that the certificate covers the education of infants and toddlers with disabilities, to the Cabinet for Health Services for approval prior to providing developmental intervention services in First Steps and shall maintain a copy of the certificate on file at the work site following approval.

      (2) A provider enrolled in an approved preparation program in IECE certification shall keep on file at the work site a copy of his/her program signed by an advisor.

      (3) A Developmental Interventionist who does not have IECE certification and is not enrolled in an approved preparation program shall maintain on file at the work site a Professional Development Plan. The plan must include documentation of competencies for each Teacher Performance Standard for IECE or strategies and timelines for meeting the skills delineated in each Teacher Performance Standard not currently met. The plan must be completed within 3 months of initial employment.

      See Attachment: Teacher Performance Standards for Interdisciplinary Early Childhood Education.

(4) Annual documentation of progress towards certification shall include a current copy of a transcript or grade card kept on file at the work
site. Progress towards meeting Teacher Performance Standards shall include portfolio entries and/or certificates of continuing education hours and/or other documentation kept on file at the work site.

B. Initial Service Coordinators who do not meet the highest entry level requirements for one of the professions delineated in 908 KAR 2:150 shall maintain on file at the work site a copy, or proof, of their bachelor's degree and documentation of two years' experience working with young children ages birth through 5 years.

Acceptable documentation may include:
(1) A signed employment application at the current work site that includes the initial service coordinator's previous work history or
(2) A letter from a previous employer or supervisor that documents the required experience.

C. Primary Service Coordinators who do not meet the highest entry level requirements for one of the professional disciplines or paraprofessional disciplines delineated in 908 KAR 2:150 shall maintain on file at the work site a copy, or proof, of their bachelor's degree and documentation of two years' experience working with young children ages birth through 5 years.

Acceptable documentation may include:
(1) A signed employment application at the current work site that includes the primary service coordinator's previous work history or
(2) A letter from a previous employer or supervisor that documents the required experience.

D. Primary Developmental Evaluators shall have on file at the work site the following:

(1) A copy, or proof, of a bachelor's degree.

(2) Documentation of two years' experience working directly with children birth through two years of age with disabilities.

Acceptable documentation may include:
(a) A signed employment application at the current work site that includes the primary developmental evaluator's previous work history and documents the required experience; or

(b) A letter from a previous or current employer or supervisor that documents the required experience.

(3) Documentation of one year experience using standardized instruments and procedures to evaluate children birth through two years of age completed either as part of formal training or supervised practice.

Acceptable documentation may include:

(a) A copy of a transcript and a copy of syllabi from supervised practica, field experiences, or coursework at a university, college, or other training site; or

(b) A letter from a former supervisor or employer documenting the experience, including the instruments used and the population evaluated.

(4) In lieu of meeting D.(3) above, the Primary Evaluator shall submit a plan and receive approval from the Cabinet for Health Services to complete a mentorship during the first year of providing primary developmental evaluation services in First Steps.

(a) Mentorship shall consist of a minimum of 4 hours every month during the first six (6) months and a minimum of 4 hours every other month during the next six (6) months of face-to-face observation and guidance that is directly related to using standardized instruments to evaluate children birth through two years of age.

(b) The mentorship plan shall include at a minimum:

- name and agency of mentor(s)
- training and experience of mentor(s)
- objectives, activities, and location for each monthly contact
- method for documentation of contacts
- method for reporting progress/results for person being mentored.

(c) All mentors shall meet the qualifications for Primary Developmental Evaluators in the First Steps system.

(d) Progress and results of mentorship shall be forwarded to the Cabinet for Health Services at the completion of the mentorship.

(e) Persons receiving mentorship shall contact the Intensive Level Evaluation team assigned to their district for

consultation, as needed, regarding individual children being evaluated.

E. Assistive technology specialists shall maintain on file at the work site the following:

(1) Documentation of extensive knowledge, training, and experience in the field of assistive technologies for infants and toddlers with disabilities.

Acceptable documentation may include:

(a) A copy of an Assistive Technology Practitioners' credential issued by the Association for the Advancement of Assistive and Rehabilitation Technology (RESNA); or

(b) Successful completion of written tests and portfolio entries as required by the Cabinet for Health Services; or

(c) A degree or credential in assistive technology from another state which includes children birth through two years with disabilities.

(2) In lieu of meeting the qualifications for professionals as required by 908 KAR 2:150 (see 1. above), a provider may submit documentation of employment by an agency that is approved by the Cabinet for Health Services to provide assistive technology services in First Steps.

2. Paraprofessionals as identified in 908 KAR 2.150 shall maintain a copy, or proof, of the required degree, certificate, diploma, license and/or certificate.

See Attachment: Summary Table of Qualifications for Paraprofessional Personnel.

A. Developmental Associates who do not have an associate degree, a child development associate certificate, or a post-secondary vocational education diploma as required in 908 KAR 2.150 but were employed as a developmental associate prior to October 1, 1997, shall document that they are working towards one of the required degrees, certificates, or diplomas or establish and maintain a professional development plan.

(1) A provider working towards an associate degree, a child development associate certificate, or a post-secondary vocational education diploma shall have a copy of his/her program signed by an advisor on file at the work site.

(2) A provider not presently enrolled in an approved program shall have a professional development plan on file at the work site that

delineates (1) a date of not later than September 1, 1998, for enrollment in an approved program, and (2) timelines for completion of the program.

(3) The professional development plan shall be submitted to the Cabinet for Health Services within 3 months of final approval of 908 KAR 2:150 or within 3 months of initial employment, whichever is later.

(4) Annual documentation of progress shall include a current copy of a transcript or grade card or a copy of an advisor's report kept on file at the work site.

3. Respite providers:

A. Shall be approved by the IFSP planning team; and

B. If employed by a program or agency, shall maintain on file at their work site documentation of meeting license, regulations, and other requirements applicable to that program or agency.

POLICY II: *Developmental Associates and Assistants shall receive supervision.*

PROCEDURES:

1. The Developmental Associate shall receive indirect supervision, consisting of on-site observation and guidance from a Developmental Interventionist for a minimum of four (4) hours per month as activities are implemented with children and families.

2. Documentation of indirect supervision shall be maintained on site and shall include the following as a minimum:
   - Name of supervisor
   - Name of person receiving supervision
   - Date and time of supervision
   - Activities and skills observed during supervision
   - Feedback given to person receiving supervision
   - Progress towards skills previously targeted by person receiving supervision
   - Plan including targeted objective(s), activities, and timeline for person receiving supervision to increase skills
   - Signatures of supervisor and person receiving supervision.

3. The Developmental Assistant shall receive direct supervision, consisting of continuous, on-site observation and guidance from a Developmental Interventionist or a Developmental Associate as activities are implemented with children and families.

4. At least once per month, the Developmental Assistant shall receive feedback from the Developmental Interventionist or Developmental Associate. Documentation of feedback shall be kept on site and shall include the following as a minimum:
   - Name of supervisor
   - Name of person receiving supervision
   - Date and time of supervision
   - Skills observed during previous month
   - Feedback regarding skills and activities that was given to person receiving supervision
   - Progress towards skills previously targeted by person receiving supervision
   - Plan including targeted objective(s), activities, and timeline for person receiving supervision to increase skills
   - Signatures of supervisor and person receiving supervision.

POLICY III: *Providers shall have knowledge of key concepts and shall exhibit skills in key practices required by the First Steps Program, as delineated in the General Roles of Professional Disciplines or the General Roles of Paraprofessional Disciplines (Attachments).*

PROCEDURES:

1. The professional provider shall have knowledge and skills to perform the following roles:

   A. Participate in the child find system.

   B. Contribute to the evaluation and assessment of the child as a member of the early intervention team.

   C. Provide family-centered and family-guided services that promote independence and self-determination.

   D. Participate as a member of an early intervention planning team to meet the identified needs of the child and the family.

   E. Provide information and training to the family, other early intervention team members, and the community.

F. Use current best practices in providing quality services to infants/toddlers with disabilities and their families and evaluates the effectiveness and efficiency of program/services on a regular basis.

G. Uphold ethical and legal standards.

H. Advocate for a high quality service delivery system.

See Attachment: General Roles of Professional Disciplines.

2. The paraprofessional provider will have knowledge and skills to perform the following roles and will perform all roles under the supervision and direction of a professional in their discipline:

A. Assist in child find activities.

B. Assist in the assessment of the child as a member of the early intervention team.

C. Assist in providing family-centered and family-guided services that promote independence and self-determination.

D. Assist in meeting the identified needs of the child and the family as a member of the early intervention team.

E. Assist in providing information and training to the family, other team members, and the community.

F. Use current best practices in providing quality services to infants/toddlers with disabilities and their families and assists in evaluating the effectiveness and efficiency of the program/services on a regular basis.

G. Uphold ethical and legal standards.

H. Assist in advocating for a high quality service delivery system.

See Attachment: General Roles of Paraprofessional Disciplines.

POLICY IV: *Providers will have knowledge and skills specific to their discipline or First Steps role.*

PROCEDURES:

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1. Professional providers shall perform the roles specific to their discipline.

   A. Audiologists shall:

      (1) Identify neonates and infants at-risk for sensorineural hearing impairment or conductive impairment.

      (2) Provide audiological screening services using behavioral and electrophysiological techniques for neonates and infants who are at risk for hearing impairment and its consequences according to the criteria outlined in the Joint Committee on Infant Hearing 1990 Position Statement.

      (3) Refer infants/toddlers identified through screening, through observation of abnormal auditory behavior or delayed speech and language development, or through referral of the family, a service provider, or a physician for medical, otological and comprehensive audiological evaluation.

      (4) Provide comprehensive audiological evaluation and assessment when indicated to determine the type, degree, configuration, and symmetry of hearing loss.

      (5) Assess and monitor middle ear function through acoustic immitance measures.

      (6) Describe the child's auditory function at various suprathreshold levels in quiet and competing signals using linguistically and developmentally appropriate test materials.

      (7) Facilitate the appropriate medical evaluations and treatment for hearing-impaired infants/toddlers.

      (8) Recommend, select, fit, and evaluate the effectiveness of sensory devices (e.g., personal hearing aids, wireless FM systems, vibrotactile units, other assistive listening devices) appropriate to the child's needs and necessary to optimize the use of residual hearing and the development of communication skills, respecting the family's values regarding the use of these.

      (9) Provide consultation or direct services in the areas of auditory training, aural rehabilitation, listening device orientation and training, and other services.

      (10) Provide ongoing monitoring of the child's hearing status, amplification needs, and development of auditory skills.

(11) Provide education and awareness for prevention of hearing loss.

B. Developmental Interventionists shall:

(1) Serve as a resource and consultant to the family and to the early intervention team regarding information and methods/techniques specific to developmental intervention.

(2) When functioning in the primary evaluator role, administer and collect formal and informal child evaluation data in the five developmental areas in a systematic way using multiple assessment instruments, measures, and sources (e.g., observations of the child in relationship to environments and interpersonal interactions, checklists, interviews, anecdotal records, normed and criterion-referenced assessments, and play-based assessments) *for the purposes of determining the child's initial and continued eligibility* consistent with Kentucky's eligibility criteria.

(3) Administer and collect formal and informal child assessment data in the five developmental areas in a systematic way using multiple assessment instruments, measures, and sources (e.g., observations of the child in relationship to environments and interpersonal interactions, checklists, interviews, anecdotal records, criterion-referenced assessments, and play-based assessments) *for the purposes of screening, programming, and performance monitoring*.

(4) Organize and communicate the results of the evaluation/assessment to the family and to other early intervention team members.

(5) Collaborate with the family and other early intervention team members to write, implement, coordinate, and evaluate the Individualized Family Service Plan (IFSP).

(6) Select, adapt, and implement curricula which address all five developmental areas based on the family's resources, priorities, and concerns, and the child's assessment data.

(7) Use information, skills, and applications learned in the interdisciplinary, collaborative team process to facilitate child development and learning.

(8) Design and adapt learning environments, both physical and instructional, and activities for infants and toddlers which promote skills acquisition in all developmental areas.

(9) Utilize instructional methodologies and materials that meet the child's individual developmental needs and incorporates family-centered activities as a part of the learning environment.

(10) Serve as primary service coordinator as determined by the family and early intervention team.

(11) Evaluate program effectiveness in respect to:
- the child's level of development and cultural background
- developmental levels and learning goals for the child
- developmentally and individually appropriate instruction
- the child's natural environment for learning
- positive guidance and self-direction
- active exploration and interaction
- use of time, space, materials, technology, and human resources (i.e., family, community, early intervention team).

(12) Supervise the Developmental Associate and the Developmental Assistant, as appropriate.

C. Family therapists shall:

(1) Educate the family about the nature of the child (e.g., the child's strengths and needs), help the family understand how the child's diagnosis will impact the family's resources, and prepare family members to cope with their child's needs on both short-term and long-term bases.

(2) Provide resources and support to the family and assist them in dealing with emotionally charged and family-related issues, e.g., stress, parent-child interactions, time management, coping, financial concerns, and impact of the child's disability on immediate and extended family members.

(3) Help support the family's present level of functioning and assist the family in adapting to the changes that may be needed to meet the challenges of parenting a child with special needs. Model this support of the family for other early intervention team members and professionals.

(4) Be "active listeners" to the family and teach this skill to family members and to other team members and professionals.

(5) Support the family in (a) being directly involved in the assessment of the child and (b) taking a leadership role in this process if they so choose.

(6) Prepare and support the family to be actively involved in developing and writing their Individualized Family Service Plan (IFSP) and to participate in the decision-making process with other team members.

(7) Facilitate the IFSP meeting, as appropriate, to ensure an open forum for discussion by all team members and support the family in assisting to conduct the team meeting, if they so choose.

(8) Observe and assess symptoms of mental health problems in the family related to the child's special needs, e.g., signs of depression, stress, etc., and provide intervention or refer the family for appropriate services.

(9) Ensure that the child's and family's psychosocial needs are addressed, in coordination with other team members.

(10) Provide guidance to the family regarding how to maximize the strengths of the child and how to cope with any problem behaviors related to the child's disability.

(11) Provide information to the family about resources and networks that can provide support to them during the child's development.

(12) Help the family problem solve ways to overcome barriers which may prevent optimal care for the child by linking with other team members, community agencies, and other services.

(13) Assist the family in maintaining and nurturing internal supports and external supports.

(14) Provide information to assist siblings and extended family members in accepting and providing support to the child and other family members.

(15) Assist the family in accessing parent-to-parent supports, parent support groups, and sibling support groups.

(16) Assist the family in undergoing transitions in the family developmental life cycle as the child transitions from early intervention services to school services.

(17) Provide crisis intervention services, as appropriate.

D. Nurses shall:

(1) Facilitate access to and communication with needed community-based medical specialty diagnostic/evaluation and tertiary providers, as well as primary referral providers, i.e., neonatal intensive care units.

(2) Systematically and continuously collect, record, and analyze comprehensive data, which may include screening and assessment of:

- health perception and health management practices;
- actual and potential safety and environment issues;
- nutritional needs and metabolic functioning;
- factors that affect activity, exercise and self-help such as neuromuscular, cardiovascular, respiratory and developmental functioning;
- elimination patterns including bowel and bladder functioning;
- cognitive/perceptual functioning;
- roles, relationships and social supports;
- coping and stress responses including family strengths and resources;
- self-perception/self-concept;
- sleep/rest patterns and needs;
- family values, beliefs, concerns and priorities within their cultural context.

(3) Analyze assessment data, utilize scientific principles and professional judgment, and collaborate with the family and other early intervention team members to determine appropriate nursing diagnoses and interventions.

(4) Prioritize nursing diagnoses based on family resources, priorities, and concerns, on actual or potential health problems, and on immediate and long-term needs of the infant/toddler and his/her family.

(5) Develop expected outcomes which support the health and development of the infant/toddler, in collaboration with the family and other team members.

(6) Ensure that development, evaluation, and revision of the Individualized Family Service Plan (IFSP) is consistent with the child's current health status.

(7) Implement interventions that:

(a) promote, maintain, or restore the infant/toddler's and family's health/physical, psycho-social, and developmental status;
(b) minimize or eliminate environmental risks;
(c) enhance the care-giving skills of the family; and
(d) prevent secondary health and developmental problems, in partnership with the family and other team members.

(8) Provide interventions which may include direct physical care, health teaching, anticipatory guidance, behavioral and early intervention strategies.

(9) Ensure that an appropriately trained health representative is available as a communication link between the child's primary care physician and the early intervention team.

(10) Provide early intervention services to medically fragile children in collaboration with the family and other team members.

(11) Teach, delegate, and supervise the performance of health related services and nursing care tasks to paraprofessionals (unlicensed health representatives).

E. Nutritionists and dietitians shall:

(1) Assess the nutritional status of children by collecting and interpreting anthropometric, biochemical, medical, socioeconomic, cultural, and dietary information.

(2) Assess feeding skill development by collecting and interpreting information regarding feeding capabilities and history, developmental status, eating environment, positioning, mealtime behavior, and parent-child interaction.

(3) Identify potential and existing nutrition problems, determining the nature and extent of nutrition or intake needs.

(4) Collaborate with the family and the early intervention team and use medical, psychological, and sociological information previously gathered to develop nutritional care plans as part of the Individualized Family Service Plan (IFSP).

(5) Provide continued instruction and support to the family and early intervention team members regarding proper diets, feeding acquisition skills, feeding equipment adaptations, proper body positioning to facilitate feeding, drug nutrient reactions, nutrition support, and other nutrition related concerns.

(6) Provide referrals to appropriate community agencies or professionals, as needed, to enhance the nutritional status or overall development of the infant/toddler.

F. Occupational therapists shall:

(1) Screen, evaluate, and assess the child's performance in collaboration with the family and the early intervention team in the following:

(a) Performance Areas
   a. Activities of daily living
   b. Play or leisure activities

(b) Performance Components
   a. Sensory Motor component
      - Sensory integration
      - Neuromuscular
      - Motor
   b. Cognitive integration and cognitive components
   c. Psychosocial skills and psychological components

(2) Identify the abilities of family members and others to interact with the infant/toddler and to facilitate development of the infant/toddler in the areas of sensory, motor, postural, fine motor-manipulative, and oral motor/feeding skills, in collaboration with the family.

(3) Interpret the evaluation and/or assessment results, discuss these with the family and other team members, and collaborate with them to develop and implement interventions, including consultation, that address the above Areas and Components.

(4) Adapt the environment, tools, materials, and activities according to the needs of the child and the resources, priorities, and concerns of the family within their social and cultural context.

(5) Provide services to prevent secondary sensory, motor, cognitive, and/or social-emotional problems.

(6) Collaborate with the family and other team members to enhance care-giving skills and to optimize the child's functional abilities.

(7) Supervise certified occupational therapy assistants (COTAs), fieldwork students, and non-occupational therapy students, as assigned.

G. Orientation and mobility specialists shall:

(1) Assist the family of an infant/toddler with visual impairment and other members of the early intervention team in conducting a functional vision assessment, particularly as related to independent travel.

(2) Instruct the child with visual impairment, in collaboration with the family and other early intervention team members, in the development of skills and knowledge that enable him/her to travel independently to the highest degree possible. Specific areas of instruction may include:

- pre-cane skills, e.g., body imagery, environmental concepts and awareness, gross and fine motor skills related to independent travel, spatial and positional concepts, social skills;
- sensory awareness, stimulation, and training
- sighted guide procedures
- basic protective and information-gathering techniques
- orientation skills
- use of residual vision
- low vision devices related to travel skills
- skills of daily living
- sensory/motor skills in coordination with the physical or occupational therapist and the teacher of visually impaired children
- cognitive concepts, e.g., size, shape, color, texture, weight, time, distance, etc.

(3) Collaborate periodically with the family and other team members to assist in environmental modifications and adaptations and to ensure reinforcement of orientation and mobility skills that will encourage the child to travel independently at home and in other natural environments.

(4) Prepare and use materials and equipment for the development of orientation and mobility skills.

(5) Introduce and provide instruction in sighted guide techniques and cane travel for the family, other team members, and those having contact with the child.

H. Physical therapists shall:

(1) Assist in designing and implementing a screening program to identify infants at risk for movement disorders, developmental delay, and sensory, orthopedic, or neurologic dysfunction.

(2) Evaluate and assess the child in the following areas in collaboration with the family and other members of the early intervention team:
   (a) functional ability, including activities of gross motor, fine motor, and perceptual motor skills;
   (b) musculo-skeletal status, including strength, joint range of motion, joint integrity, and posture;
   (c) neuromotor assessment, including reflex development, postural responses, and analysis of movement patterns;
   (d) sensory status, including tactile, proprioceptive, and vestibular.

(3) Identify, select, evaluate, and recommend or fabricate/adapt therapeutic equipment in collaboration with the family, including orthotics, positioning aids, mobility devices, toys, and aids for activities of daily living, in order to enhance participation of the child and/or prevent regression, deformity, discomfort, or pain.

(4) Collaborate with the family and other team members to identify, evaluate, and design accessible environments to promote the child's independence.

(5) Select, individualize, and implement developmentally appropriate physical therapy intervention strategies in collaboration with the family and other team members to maximize the child's sensorimotor potential and to prevent or alleviate movement dysfunction and related functional problems.

I. Physicians shall:

(1) Assure periodic health and developmental screening to identify infants/toddlers who have a high probability of exhibiting developmental delay (cognitive, communication, physical, social/emotional or adaptive) or atypical development and who need more in-depth evaluation.

(2) Conduct medical histories and review pertinent records related to the child's current health status and medical history.

(3) Conduct a thorough medical evaluation (neuro-musculo-skeletal, cardiopulmonary, motor, vision and hearing, etc.) inclusive of laboratory tests, x-rays, and other ancillary assessments appropriate to the physician's specialty, as indicated.

(4) Identify infants/toddlers who may have a developmental disability or confirm and document an established risk factor.

(5) Send medical records to First Steps Point of Entry (POE) and refer the child to other physicians with the family's consent and support for referral.

(6) Participate in the evaluation and assessment of the child's development, including physical development and health patterns.

(7) Counsel and interpret to the family the significance of various medical findings upon the child's immediate and long-term functioning.

(8) Facilitate access to and communication with needed tertiary and community-based medical specialty diagnostic/evaluation providers.

(9) Prescribe treatment for physical conditions.

(10) Participate in initial and follow-up Individualized Family Service Plan (IFSP) team meetings in one or more of the following ways:

- attend the IFSP meeting;
- make pertinent records available to the team;
- discuss the child's health needs with the service coordinator or send a knowledgeable staff person to the IFSP meeting;
- review nursing diagnoses;
- review the service plan to be sure the health needs of the child have been addressed appropriately and in a sufficiently comprehensive manner.

(11) Review and sign appropriate therapy orders to ensure that the child receives these services.

(12) Implement or assist the family and/or other team members to implement medical plans to treat underlying causes.

(13) Maintain communication with the child's service coordinator or ensure that an appropriately trained health representative is available as a communication link between the child's primary care physician and the early intervention team.

(14) Provide ongoing acute and preventative care.

(15) Provide medical consultation or facilitate access to physician consultants or medical procedures, as indicated.

(16) Advocate for the medical/health needs of children and families.

J. Psychologists and certified psychologists with autonomous functioning shall:

(1) Conduct clinical evaluations, i.e., administer psychological and developmental instruments appropriate for infants/toddlers, to determine eligibility for early intervention services and interpret these to the family and other members of the early intervention team.

(2) Assess the infant/toddler's neurodevelopmental and behavioral status as well as emerging cognitive, behavioral, social, and emotional functioning, using appropriate methods and tools and in collaboration with the family and other members of the team.

(3) Identify the family's psychosocial status, i.e., parenting and caregiving skills, family-child transactions, mental health, and appropriate developmental expectations.

(4) Develop and manage a program of psychological services in collaboration with the other team members to include, as appropriate, psychological counseling for infants/toddlers and their families, family counseling, and intervention for behavioral, developmental, social, and mental health issues.

(5) Provide emotional support and counseling to the family to foster acceptance of the child's status and to cope with stress and support issues based on short- and long-term implications of raising a child with special needs.

(6) Assist the family to improve family functioning, parenting skills, knowledge of typical and atypical cognitive development and behavior patterns, advocacy skills, and/or behavior management skills on a systematic basis.

(7) Provide consultation services, both formal and informal and in a collaborative manner, to the family and other team members in all intervention settings regarding developmental and/or behavioral issues.

(8) Provide therapeutic mental health care to a child with emotional or mental illness.

(9) Supervise certified psychologists or psychological associates (licensed psychologist only).

K. Psychological associates shall:

(1) Perform the functions of the psychologist, but only under the supervision of a licensed psychologist. The psychological associate shall not practice independently or supervise certified psychologists or other psychological associates.

L. Social workers shall:

(1) Conduct home visits to gather and evaluate information regarding the child's living conditions and patterns of family-child interaction.

(2) Prepare a psychosocial developmental assessment of the child within the family context.

(3) Use interviewing and observation skills to determine the family's capacity to provide and manage basic nurturant needs (e.g., food, shelter, protection, medical care, employment, etc.) and assume primary responsibility for linkages to concrete resources to assist in provision of those needs.

(4) Facilitate the education of the family regarding diagnosis, community resources, family-child and family-therapist/interventionist interactions.

(5) Build a partnership with the family to facilitate/maximize active participation in early intervention activities and model family-professional partnerships.

(6) Enhance the family's ability to utilize its own strengths, including the strengths of a non-traditional family, and other available support systems.

(7) Use the family's own expertise to collaborate with other members of the early intervention team regarding the complexity of interactive family factors, socio-cultural contextual factors, and structural factors of race, income, and gender, which can strengthen or inhibit child development and family well-being.

(8) Implement appropriate social skill-building activities with the child and family.

(9) Refer for or provide direct and ongoing social work services to strengthen the family (e.g., crisis intervention, grief counseling, child management, marriage and family therapy, substance abuse counseling, child support, communication and relational training, etc.), utilizing individual, family, and group methods. (Counseling services may only be provided by master's level personnel.)

(10) Identify conflicts and potential conflicts within the child's service delivery system and act as a mediator to resolve these at the lowest level possible while preserving the integrity and effectiveness of the system.

(11) Work to alleviate those problems/barriers in the child's and family's environment and community that affect the child's maximum utilization of early intervention services.

(12) Provide group work services to encourage the growth and development of the infant/toddler and family through expertise in group formation, group composition, group dynamics, and group process.

(13) Assist the local lead agency in determining a child's need for a surrogate parent.

M. Speech language pathologists shall:

(1) Screen infants/toddlers in communication and language skills and in oral-motor development.

(2) Evaluate and assess infants/toddlers in collaboration with the family and other members of the early intervention team in the following areas:

(a) Levels of functioning for cognitive prerequisites, e.g., symbol use, means-ends relationships, object permanence, etc.

(b) Family-child interactions and responses to determine communicative intent.

(c) Levels of play development for interaction with both objects and individuals in the environment, involving skills such as joint regulation, turn-taking, etc.

(d) Utilization of non-verbal communication behaviors and functions.

(e) Levels of functioning for spoken language involving both receptive and expressive areas to include phonological skills, semantic abilities, syntactic abilities, and pragmatic skills. Early literacy skills should be included, as appropriate.

(f) Structure and function of the oral mechanism as it relates to speech production and attainment of feeding skills.

(g) Parameters of speech production, including respiration, articulation/phonology, voice, fluency, and resonance, as appropriate.

(h) Use of augmentative and alternative communication systems as related to the specific needs of the child and family.

(i) Oropharyngel swallowing ability via video fluoroscopy.

(3) Develop a plan and provide intervention specific to communication and language development and oral-motor skills in collaboration with the family and other team members.

(4) Select and develop augmentative and alternative communication systems as appropriate and in collaboration with the family and other team members, and provide consultation and training in their use.

(5) Provide consultation or direct services in the areas of auditory training, aural habilitation, listening device orientation and training, and other services.

N. Teachers of children who are deaf or hard of hearing shall:

(1) Participate in screening, evaluation, and assessment pertaining to communication, speech, language, and cognitive development for infants and toddlers in collaboration with the family and other early intervention team members, selecting instruments that are appropriate for infants/toddlers who may be deaf or hard of hearing, using the child's mode of communication and primary language, and modifying the assessment procedures based on the child's hearing loss.

(2) Assist in the identification of an accompanying visual impairment that may result in a dual sensory impairment.

(3) Interpret the results of evaluations and assessments with respect to the child's hearing loss and explain the nature, scope, and implications of the loss to the family and other team members.

(4) Provide information to the family and other team members regarding the typical development of communication/language skills in young children and the relationship of the child's auditory functioning level to his/her early development of cognition, communication, speech, motor, adaptive and social-emotional skills.

(5) Assist in the identification of risk factors that contribute to hearing loss, its possible progression, and associated developmental delays.

(6) Provide information to the family regarding educational issues, e.g., the range of language and communication options that are available, the various educational placements, different methodology approaches, etc.

(7) Assist in determining the benefits of various sensory devices and their effects on the child's use of residual hearing.

(8) Analyze routine activities with the family and other team members to determine the potential for increasing the child's auditory awareness and language skills on a daily basis.

(9) Provide auditory training and aural habilitation and facilitate spoken and/or sign language acquisition in collaboration with the family and other team members and as written in the Individualized Family Service Plan (IFSP).

(10) Provide information to the family and other team members regarding the functioning, use, and care of sensory devices and assist them in observing and monitoring ongoing benefits.

(11) Assist the family in gaining access to play groups and other opportunities for the infant/toddler to develop communication skills related to socialization.

(12) Facilitate access to adults and peers who communicate in the child's primary language and communication mode and to families with a member who is deaf or hard of hearing as resources and supports, if the family so chooses.

(13) Inform the family of legislation that pertains to children who are deaf or hard of hearing and assists them in accessing resources available at the local, state, and national level for children who are deaf or hard of hearing and their families.

(14) Assist the family and other team members in addressing issues of cultural diversity and the Deaf culture as they affect children who are deaf or hard of hearing and their families.

O. Teachers of children with visual impairments shall:

(1) Provide functional vision assessments for a child with a visual loss and his/her family in collaboration with the family and other members of the early intervention team.

(2) Interpret the results of such assessments and of the child's specific eye condition and share information regarding intervention implications with the family and other team members.

(3) Provide information to the family and other team members pertaining to the development and unique learning characteristics of a child with a visual impairment and assist them in understanding the child's abilities, expected progress, and realistic goals.

(4) Assist in the identification of an accompanying hearing impairment that may result in a dual sensory impairment.

(5) Assure that the needs of the child and family for special services, instruction, equipment, and materials related to the visual impairment are addressed in the Individualized Family Service Plan (IFSP), in collaboration with the family and other team members.

(6) Provide consultation or direct intervention to meet the educational needs of the child and family as related to the visual impairment, in collaboration with other team members.

(7) Assist the family and other team members in adapting environments and developing strategies to meet the needs of the child and to ensure the child's participation in activities in natural environments.

(8) Assure that specialized materials, e.g., auditory and tactile materials, needed by the infant/toddler with visual impairment to enhance sensory stimulation, concept development, and readiness skills are obtained.

(9) Instruct the child, family, and other team members in pre-orientation and mobility skills, as appropriate and as written in the IFSP.

(10) Instruct the child, family, and other team members in pre-Braille skills, as appropriate and as written in the IFSP.

(11) Assist the family and other team members in becoming aware of and accessing the services, supports, and resources available at the local, state, and national levels for children with visual impairments.

(12) Provide inservice training to families, professionals, team members, and the community regarding the needs of children with visual impairments and appropriate adaptations, programs, and services for them and use various materials to promote public awareness.

2. Paraprofessional providers will perform the roles specific to their discipline under the direction and supervision of a professional in their discipline.

A. Under the supervision of a registered and licensed occupational therapist (OTR/L), certified occupational therapy assistants shall:

(1) Respond to a request for service by relaying the information or referral to the supervising OTR/L.

(2) Assist with screening, data collection, and the evaluation and assessment process.

(3) Assist the OTR/L in the development, coordination, and implementation of the Individualized Family Service Plan (IFSP) and in activities and techniques to implement the plans, in collaboration with the family and other members of the early intervention team.

(4) Recommend adaptations to the OTR/L and adapt the natural environment, tools, materials, and activities according to the needs of the infant/toddler and his/her sociocultural context and in collaboration with the family.

(5) Assist in orienting and instructing the family and other team members in activities which support the intervention plan.

(6) Monitor the child's responses to intervention, report changes in status to the OTR/L, and modify intervention as indicated in collaboration with the family.

(7) Assist the OTR/L in program evaluation and quality improvement activities.

(8) Assist in providing inservice education and in supervising fieldwork students and non-occupational therapy students, as assigned.

B. Under the indirect supervision of and in collaboration with a developmental interventionist, developmental associates shall:

(1) Serve as a resources and consultant to the family and other early intervention team members regarding information and methods/techniques specific to developmental intervention.

(2) Assist in collecting formal and informal child assessment data in the five developmental areas in a systematic way using appropriate assessment instruments, measures, and sources (e.g., observations of the child in relationship to environments and interpersonal interactions, checklists, interviews, anecdotal records, criterion-referenced assessments, and play-based assessments) *for the purposes of screening, programming, and performance monitoring*.

(3) Organize the results of the assessments and communicate those to the developmental interventionist.

(4) Use information, skills, and applications learned in the interdisciplinary, collaborative team process to facilitate child development and learning.

(5) Design adaptive learning environments, both physical and instructional, and activities for infants and toddlers which promote skills acquisition in all developmental areas.

(6) Implement curricula which address all developmental areas.

(7) Utilize appropriate instructional methodologies and materials that meet the child's individual developmental needs and incorporate family-centered activities as a part of the learning environment.

(8) Supervise developmental assistants in consultation with a developmental interventionist, as appropriate.

C. Under direct supervision of a developmental interventionist and/or a developmental associate, <u>developmental assistants</u> shall assist in:

(1) Collecting formal and informal child assessment information.

(2) Serving as a resource to the family and other early intervention team members regarding information and methods/techniques specific to the child's developmental intervention.

(3) Designing adaptive learning environments, both physical and instructional, and activities for infants and toddlers which promote acquisition of skills in all developmental areas.

(4) Implementing curricula which address all developmental areas.

(5) Utilizing appropriate instructional methodologies and materials that meet the child's individual developmental needs and incorporate family-centered activities as a part of the learning environment.

D. Under the direction of a registered nurse, physician, or dentist, licensed practical nurses shall:

(1) Contribute to the ongoing assessment of the health status of the infant/toddler by:

(a) Collecting information from relevant sources regarding the biological, psychological, social and cultural factors of the infant/toddler's life and the influence these factors have on the child's health status. Data should include observations of appearance and behavior, measurements of physical structure and physiologic function, and observation of the child's subjective and objective signs and symptoms.

(b) Interpreting data, including recognizing existing relationships between data gathered and the child's health status, current plan of care, and medical treatment; determining need for nursing intervention based on the data gathered; and appropriate consultation.

(2) Participate with the registered nurse, the family, and other team members in developing appropriate outcomes and interventions which support the health and development of the infant/toddler as part of the Individualized Family Service Plan (IFSP) process.

(3) Procure resources and implement interventions in partnership with the family and other team members that:
(a) promote, maintain, or restore the infant/toddler's and family's health/physical, psycho-social, and developmental status;
(b) minimize or eliminate environmental risks;
(c) enhance the care-giving skills of the family; and
(d) prevent secondary health and developmental problems.

(4) Recognize the child's responses to interventions and modify interventions based on the child's status.

(5) Collaborate in implementing the child's intervention plan with the family and other team members whose services may have a direct or indirect effect upon the child's health care.

(6) Provide accurate and consistent information, demonstration, and guidance to the infant/toddler's family, significant others, or other team members in order for the child to reach an optimum level of health functioning and participate in self-care and to reinforce the developmental interventions of other team members.

(7) Report and record in a timely manner all aspects of nursing care for which the licensed practical nurse is responsible.

(8) Participate with the registered nurse, the family, and other team members in collecting evaluative data, determining the extent to which desired outcomes are being met, and planning for continued nursing intervention as part of the Individualized Family Service Plan (IFSP).

(9) Receive supervision in the performance of any nursing activity, as determined by the following variables:

(a) Educational preparation, including both the prelicensure program and subsequent continuing education and practice;

(b) Stability of the child's condition, involving both the predictability and rate of change; highly predictable change requires minimal supervision, while an unpredictable or unstable condition requires direct, on-site supervision;

(c) Complexity of the nursing task, which includes the task's potential impairment to the child's well-being and the degree to which scientific knowledge is used to make judgments when performing the task.

(10) Teach, delegate, and supervise the performance of nursing care tasks to other licensed practical nurses provided the person is competent to perform the task in a safe and effective manner and provided the task is within the scope of the person's nursing practice.

E. Under the supervision of a licensed physical therapist, physical therapy assistants (PTAs) shall:

(1) Relay referrals to the physical therapist.

(2) Assist the physical therapist in observing and screening infants and toddlers with physical/motor disabilities, using formal or informal procedures, and in recording and documenting the results.

(3) Establish relationships with the family, other members of the early intervention team, and other programs/agencies as well as with members of the physical therapy team.

(4) Provide direct intervention services (e.g., positioning, exercise, developmental activities) based on the IFSP, including the integration of non-physical therapy outcomes in a transdisciplinary model.

(5) Assist in instructing the family and other team members in positioning and handling techniques, safety precautions, and body mechanics and in monitoring management techniques as instructed by the physical therapist.

(6) Document intervention procedures and results and regularly inform the physical therapist of progress and of any modifications that may be appropriate for the child and family.

(7) Monitor the status of equipment and materials, maintain these, and notify the physical therapist of the need for repair, modification, or replacement.

(8) Participate in the program planning process as a member of the physical therapy team and assist the physical therapist in the management and maintenance of the program, including record-keeping and reporting.

(9) Assist the physical therapist in providing information regarding physical/motor disabilities and physical therapy functions and services on a formal or informal basis to the family, other team members, and community agencies and personnel.

(10) Assist the physical therapist in clinical internship activities for students enrolled in physical therapy assistant programs.

(11) Request direction or consultation from the physical therapist as necessary.

F. Under the supervision of a licensed speech-language pathologist and when employed in a public school setting, speech-language pathology assistants (SLPAs) shall:

(1) Relay referrals to the supervising speech-language pathologist.

(2) Screen infants/toddlers in communication and language skills and in hearing without interpretation, using procedures developed by the speech-language pathologist and the audiologist respectively, and record and document the results.

(3) Assist in assessing infants and toddlers.

(4) Provide intervention services specific to communication and language development in collaboration with the family and other team members and in accordance with the Individualized Family Service Plan (IFSP).

(5) Document intervention procedures and progress toward IFSP outcomes and regularly inform the speech-language pathologist of progress and of revisions and modifications that may be appropriate for the child and family.

(6) Monitor the status of materials and equipment, maintain these, and notify the speech-language pathologist of the need for repair, modification, or replacement.

(7) Assist the speech-language pathologist in providing information regarding speech-language and communication functions and services on a formal or informal basis to the family, other team members, other agencies/programs, and the community.

(8) Participate in the program planning process as a member of the team and assist the speech-language pathologist in the management and maintenance of the program, including record-keeping, clerical duties, and reporting.

(9) Request direction or consultation from the speech-language pathologist as necessary.

3. Providers in service positions recognized by First Steps will perform the roles specific to their positions.

A. Within the scope of their competence, considering their level of education, experience and training, assistive technology specialists shall:

(1) Observe and assess the strengths and needs of the infant/toddler in collaboration with the family and other early intervention team members and suggest assistive technologies that may be employed to meet the child's needs.

(2) Plan assessment activities to explore the feasibility and projected successfulness of various assistive technologies, including hardware, software, and peripherals, that may be appropriate for the child, in collaboration with the family and other early intervention team members.

(3) Select and recommend assistive technologies that are appropriate for the child and that will promote the attainment of the Individualized Family Service Plan (IFSP) outcomes in collaboration with the family and the early intervention team.

(4) Ensure provision and implementation of the assistive technologies as specified in the IFSP.

(5) Design strategies for the use of the assistive technologies selected that will ensure integration of the child into daily routines and normal environments, in consultation with the family and other early intervention team members.

(6) Design, fabricate, adapt and/or customize devices and materials to assist the child in functioning in his/her environment, to promote independence, and to assist in increasing skills as delineated in the IFSP.

(7) Assist in obtaining funding for technological devices and materials, if necessary.

(8) Provide ongoing training and technical assistance in the implementation of the selected assistive technologies to the infant/toddler, the family, other early intervention team members, and those who interact with the infant/toddler to ensure appropriate and continued implementation and achievement of the IFSP outcomes.

(9) Assist in coordinating assistive technology services and in integrating services for the child and family across disciplines, service providers, and agencies.

(10) Monitor and evaluate the effectiveness of the assistive technologies and the strategies for using them and assists in revising plans accordingly, in collaboration with the family and other early intervention team members.

(11) Assist in integrating assistive technology services across programs and service delivery systems during the transition of the child and family from early intervention to the next placement.

(12) Provide current information regarding assistive technologies to other programs, agencies, and the community and advocate to alleviate the barriers that limit services to the child and family.

B. Initial service coordinators shall:

(1) Coordinate and actively participate in public awareness and child find activities.

(2) Determine the nature of each referral and the appropriate follow-up contacts.

(3) Provide intake into the early intervention system, including obtaining necessary information and releases.

(4) Inform the family of their rights and safeguards and of the availability of advocacy services.

(5) With the family's consent, meet the family in their home or at another location as preferred by the family to assist in identifying their priorities, resources and concerns.

(6) Secure medical information and history and recent evaluations and assessments of the child and arrange for additional ones, as needed.

(7) Ensure that eligibility for early intervention services is determined for the child.

(8) Prepare families for and enable them to participate in all aspects of the early intervention process.

(9) Coordinate, facilitate, and participate in development of the initial Individualized Family Service Plan (IFSP).

(10) Assist the family initially in reviewing available resources, services, and providers and in identifying other possible options.

(11) Ensure that a primary service coordinator is designated.

(12) Ensure procedural safeguards, including confidentiality and timely delivery of initial services.

(13) Maintain ongoing tracking data and accurate records pertaining to children and families served and to available resources.

(14) Maintain communication and linkages with the District Early Intervention Committee (DEIC), local Preschool Interagency Planning Councils (PIPCs), and other community and local interagency groups in order to:
   (a) share information, in accordance with procedural safeguards;
   (b) address service coordination and child find/public awareness issues; and
   (c) refine the service coordination system, as appropriate.

(15) Establish and maintain cooperative and collaborative relationships with referral sources and service providers.

(16) Identify continuing education needs for self, families, and colleagues and seek resources, information, and training opportunities to meet these.

C. Primary service coordinators shall:

(1) Participate in child find and public awareness activities or systems.

(2) Coordinate ongoing assessments and evaluations and promote early intervention teaming during these processes.

(3) Assist the family in developing a system for gathering and maintaining pertinent information and records.

(4) Ensure identification of the family's resources, priorities, and concerns on an ongoing basis and develop a partnership with the family through regular contacts.

(5) Coordinate, facilitate and participate in the development, review, evaluation, and updates of the Individualized Family Service Plan (IFSP) with the family and other members of the early intervention team on an ongoing basis.

(6) Facilitate, enable, and ensure the family's involvement and decision-making authority throughout the information-gathering process and the planning, development, implementation and evaluation of the IFSP.

(7) Assist the family in identifying and accessing appropriate services, resources, and providers for their child and their family.

(8) Serve as a single point of contact, in collaboration with the family, to coordinate, monitor, and ensure effective and efficient delivery

of services that are pertinent to the child's and family's total service needs and assure that duplication and fragmentation are avoided.

(9) Facilitate collaboration and mediation among the family and service providers to ensure an integrated transdisciplinary process and to strengthen the family's ability to coordinate services for their child.

(10) Assist the family in times of crisis or unexpected events.

(11) Coordinate and facilitate development of plans for transition to preschool or other placement as part of the IFSP in a timely manner as defined by law.

(12) Ensure the faithful implementation of all procedural safeguards, including the family's right to implementation of the IFSP, the right to privacy under the Family Education Rights and Privacy Act (FERPA), the right to due process, and the right to advocate for additional services as may be determined necessary to meet the needs of the child and family.

(13) Maintain accurate records and ongoing data regarding the children and families served, send records and data to the Point of Entry as outlined in the Records section of this manual, and assist in refining the service coordination system, as appropriate.

(14) Facilitate and participate in the evaluation of individual service outcomes and the evaluation of the Kentucky Early Intervention System (KEIS).

(15) Identify continuing education needs for self, families, and colleagues and seek resources, information, and training opportunities to meet these.

D. Primary developmental evaluators shall:

(1) Gather information from the family and other sources pertaining to medical history and evaluation, vision and hearing screening, developmental progress, and results of previous evaluations and assessments.

(2) Administer standardized evaluation instrumentation and procedures in the five skill areas (i.e., cognitive development, communication development, physical development, emotional/social development, adaptive development), in

collaboration with the family and other early intervention team members.

(3) Write evaluation reports, which include identifying information; birth, medical/health, and developmental history; current services; behavioral observations; evaluation procedures, tests administered, and results; impressions and conclusions/diagnoses; contributing factors, including family's evaluation of test accuracy; and recommendations.

(4) Interpret evaluation results and recommendations to the family and the early intervention team in language that is easily understood and is appropriate to the family.

(5) Collaborate with the family, service coordinator, and other early intervention team members in regard to further evaluation when needed or when results of the primary evaluation are inconclusive.

(6) Collaborate with the family and the early intervention team in determining the eligibility of the child and family for services, using the First Steps eligibility criteria; in identifying the family's resources, priorities, and concerns; and in developing an Individualized Family Service Plan (IFSP).

Personnel

GUIDING PRINCIPLES

• Use "people first" language. People with disabilities are people first and they happen to have a disability. Therefore, the person should be mentioned first and disability second. For example, "a person with mental retardation" is appropriate while "a mentally retarded person" is inappropriate.

• Use the term "the identification of family resources, priorities and concerns" in place of the term "family assessment". Current legislation uses the phrase "the identification of family resources, priorities and concerns". Families are opposed to the term "family assessment" as it implies something is wrong with the family. The current terminology (identification of resources, concerns and priorities) implies a positive attitude about young children and their families.

• Use the term "service coordinator" in place of the term "case manager". This reflects current legislation and also reflects the preferences of families.